



COMPREHENSIVE CANCER CENTERS

User Electronic Mail Authorization Form Patient Portal: My Care Plus

My Care Plus, the Patient Portal (the "Portal") offers convenient and secure access to your personal health record. As the patient, you are in control of your Portal record: we will not activate your personal account unless you authorize us to do so.

Because personal identifying information is available via the Portal, it is very important that you keep your password private. Do not share your password with anyone or write it in a place easily accessible to others.

If you choose not to execute this User Electronic Mail Authorization Form, you will not be able to access the Portal. If you choose to submit this form, you understand you are consenting for us to email you a unique link that you will use to create a password in order to access the Portal. **Please look for an email from My Care Plus promptly after submitting this form.** For your protection, the link is designed to expire quickly if not used. If you should change email addresses, please contact your physician's office in order to provide your new email contact information so that you will continue to receive updates and other pertinent information. Please choose an email address that will not be subject to access by anyone you do not trust.

If you wish to discontinue utilizing the Portal, please contact your physician's office.

Terms

You are receiving access to the Portal, the terms and conditions of the Portal shall apply to this User Electronic Mail Authorization Form. If you do not have e-mail access, please check the box and sign at the bottom.

Patient Name
(First Name, Middle Initial, Last Name)

Date of Birth of Patient

I do not have e-mail access.

I do not want access to the portal.

Authorized user is:

Authorized User Name (If different from patient)

- Patient
- Patient's Guardian (or parent of un-emancipated minor patient)
- Person authorized to make decisions on behalf of patient (e.g. by a medical power of attorney)

Email Address of Patient or Authorized User

Physician's Name

Authorized Signature

Date

Signature of Practice Staff
[Confirming user's identity and authority]

Date

Note to Staff: Accept this form only when the identity and authority of the signing person has been confirmed, and the signing person (i.e., the Authorized User) understands and agrees to use the listed email address for this purpose.

Staff Use Only:	MRN _____
Email in PMS _____	iKM Consent _____